PRINTED: 01/17/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		ONSTRUCTION 00	(X3) DATE COMPI	
		152027	B. WIN			10/02	/2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE AIRFIELD AVE		
VIBRA H	OSPITAL OF FOR	T WAYNE		FORT \	WAYNE, IN 46807		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPED DEFICIENCY)		COMPLETION
TAG S0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
30000							
	The visit was fo	r investigation of a	S00	00			
	licensure hospita	al complaint.					
	Complaint Num	ber:					
	IN 00108917						
		Deficiencies cited related					
	to the allegation	S.					
	Date: 9-06, 9-0	7 and 10-02-12					
	Facility Number	r: 012132					
	Surveyor:						
	Brian Montgom	ery, RN, BSN					
	Public Health N	•					
		•					
	QA: claughlin	12/14/12					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		152027	B. WING			10/02/	2012
			B. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AIRFIELD AVE		
\/IDDA LI	OSPITAL OF FORT	- WAYNE			VAYNE, IN 46807		
VIDICATIO	OSFITAL OF FORT	WATNE		FORT	VATNE, IN 40807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
S0322	410 IAC 15-1.4-1					•	
	GOVERNING BO	ARD					
	410 IAC 15-1.4-1	(c)(6)(H)					
		board is responsible					
	for managing the	•					
	governing board	shall do the					
	following:						
		ne chief executive					
		oolicies and programs					
	for the following:						
	(H) Requiring all s	services to have					
	policies and proce						
	•	ed and reviewed at					
	least triennially.						
		review and interview, the	S032	2	Correction:		01/18/2013
		cer failed to ensure that	5032		· Policy developed to address		01/10/2015
	policies/procedures	for all services were updated			· · ·		
		rsing and medical records			patient discharge		
	(MR) services.				O submittal of policy through next		
	,				scheduled Quality, MEC, GB		
	Findings:				meetings		
	Č				· Policy developed to address		
	1. On 10-02-12 at 0	945 hours, staff A2 was			requirements for all medical record		
	requested to provide	e a policy/procedure regarding			entries to be authenticated, dated		
		higher level of care and none			timely		
	was provided prior t	_			O submittal of policy through next		
					scheduled Quality, MEC, GB		
	_	iew on 10-02-12 at 1535			meetings		
		irmed that no transfer			Prevention:		
	policy/standard of c	are was available regarding			· Staff in-service on new		
	patient transfers to a	higher level of care.			policies Poenensible Portus Chief		
					Responsible Party: Chief Executive Officer (CEO), Chief	f	
		945 hours, staff A2 was			Clinical Officer (CCO), Directo		
		e a policy/procedure assuring			Medical Records (DMR)	1	
		shall be complete and shall be			iviculcal Necolus (DIVIN)		
		ated in a timely manner and					
	none was provided p	prior to exit.					
	4. During an intervi	iew on 10-02-12 at 1500					

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		IDENTIFICATION NUMBER: 152027	A. BUILDING B. WING	00	COMPLETED 10/02/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
VIBRA H	OSPITAL OF FORT			WAYNE, IN 46807	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	policy/procedure Macked the requirem policy/procedure was	A4 confirmed that the edical Record Content #6073 ents and confirmed that the as the standard of care for ing MR documentation.			

State Form Event ID: XGT811 Facility ID: 012132 If continuation sheet Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		152027	B. WIN			10/02/	/2012
			Б. WП		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AIRFIELD AVE		
VIBRA H	OSPITAL OF FORT	WAYNE			WAYNE, IN 46807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	1		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	DATE
S0744	410 IAC 15-1.5-4	· · · · · · · · · · · · · · · · · · ·	1				
007 11	MEDICAL RECO						
	410 IAC 15-1.5-4						
		(-/()					
	(e) All entries in the	he medical record					
	shall be:						
	(1) legible and co	mplete;					
	_	ent review and interview, the	S07	'44	Correction:		01/18/2013
	_	ure all medical record (MR)			· Policy developed to address		
	_	ete for 4 of 8 records reviewed			patient discharge including handoff		
	(patient #'s 23, 26, 2	27 and 30)			report process		
					O submittal of policy through next	t	
	Findings:				scheduled Quality, MEC, GB		
					meetings		
		umentation for patient 23			 Policy developed to address 		
		signature, date and time by the			requirements for all medical record		
	responsible nurse co	ompleting the entry.			entries to be authenticated and		
					dated timely		
	-	iew on 10-02-12 at 1545			O submittal of policy through next	t	
	· ·	firmed that the transfer record			scheduled Quality, MEC, GB		
	-	d authentication by the			meetings		
	responsible nurse.				· Director of Quality		
	2 The MD for notice	ents 26 and 27 lacked			Management (DQM) or designee to)	
	-	d 'Communication For Other			inform clinical staff of		
		d communication For Other			documentation non-compliance		
		in the MR for patients 22, 23,			including transfer form as		
	24, 25, 28 and 30.	1711c 101 patients 22, 23,			appropriate		
	21, 23, 20 and 30.				· CCO to enforce compliance		
	4. During an interv	iew on 10-02-12 at 1545			per policy		
	-	firmed that the document was			Prevention:		
		ned that the MR for patients			· Staff in-service on new		
	_	e indicated documentation.			policies		
					· Daily review of		
	5. The MR nurses r	notes and transfer record for			documentation for 30 days and		
	patient 30 lacked do	ocumentation that report was			monthly thereafter until compliance	е	
	called to the receivi	ng facility.			target achieved and maintained		
					Responsible Party: DQM, CO	O	
	6. During an interv	iew on 9-06-12 at 1550 hours,					
	staff A4 confirmed	that the MR documentation for					
			1		1		Î.

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OF CORRECTION	IDENTIFICATION NUMBER: 152027	(X2) MULTIPLE CO A. BUILDING B. WING	00	10/02	ESURVEY LETED 2/2012
PROVIDER OR SUPPLIER		2626 FA	ADDRESS, CITY, STATE, ZIP COI AIRFIELD AVE VAYNE, IN 46807	DE	
OSPITAL OF FORT SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) indicate that report was called	STREET A 2626 FA	AIRFIELD AVE	DE CTION J.LD BE	(X5) COMPLETION DATE

State Form Event ID: XGT811 Facility ID: 012132 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027			LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2012		
	ROVIDER OR SUPPLIER			2626 F	ADDRESS, CITY, STATE, ZIP CODE AIRFIELD AVE WAYNE, IN 46807		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
S0748	in accordance with Based upon docume facility failed to ensure record (MR) were a promptly for 4 of 8 23, 25, 26 and 30). Findings: 1. The MR docume 'Communication Fosignature and date be completing the entry A3 confirmed that the 23 lacked a signature nurse. 3. The policy/proce (revised 3-11) indicand Admission and Assecompleted by the numbours of admission. and cosigned by an 4. The nursing Admission policy Admission Assessment of the admission policy Admission Assessment (revised 3-11) indicand cosigned by an 4. The nursing Admission policy Admission Assessment (revised 3-11) indicand cosigned by an 4. The nursing Admission policy Admission Assessment (revised 3-11) indicand cosigned by an 4. The nursing Admission policy Admission Assessment (revised 3-12) indicand (revised 3-12) i	ne medical record and dated promptly h subsection (c)(3). ent review and interview, the ure all entries in the medical uthenticated and dated records reviewed (patient #'s ntation for patient 23 titled r Other Facility ' lacked a y the responsible nurse where the transfer record for patient e and date by the responsible dure Admission of a Patient atted the following: "The essment Record must be urse admitting within four (4) It may be signed by an LVN	S07	48	Correction: Policy developed to address requirements for all medical record entries, including nursing documentation to be authenticated and dated timely submittal of policy through next scheduled Quality, MEC, GB meetings Director of Quality Management (DQM) or designee to inform clinical staff of documentation non-compliance CCO to enforce compliance CCO to enforce compliance per policy Prevention: Staff in-service on new policies Daily review of documentation for 30 days and monthly thereafter until compliance target achieved and maintained Responsible Party: DQM, CO		01/18/2013

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		IDENTIFICATION NUMBER: 152027	A. BUILDING B. WING	00	COMPLETED 10/02/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
VIBRA H	OSPITAL OF FORT	WAYNE		AIRFIELD AVE WAYNE, IN 46807	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	hours, staff A3 conf	iew on 10-02-12 at 1550 irmed that the medical records documentation by nursing			

State Form Event ID: XGT811 Facility ID: 012132 If continuation sheet Page 7 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027			LDING	ONSTRUCTION 00	(X3) DATE : COMPL 10/02/	ETED	
	PROVIDER OR SUPPLIER			2626 F	ADDRESS, CITY, STATE, ZIP CODE AIRFIELD AVE NAYNE, IN 46807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
S0930	following: (3) A registered n and evaluate the provided to each Based upon docume registered nurse fail was provided, evaluaccordance with phymedical records (MI Findings: 1. The policy/proce #6073 (revised 4-11 "Nurses notes and e contain pertinent an observations. This is the respective forms Records Committee 2. The MR for patie by nursing staff indice out of Bed with ass 3. The MR for patie by nursing staff indice out of Bed with ass 17 days. 4. The MR for patie by nursing staff indice out of Bed with ass 17 days.	ervice shall have the urse shall supervise care planned for and patient. ent review and interview, the ed to ensure that patient care ated and documented in ysician orders for 4 of 8 R) reviewed. dure Medical Record Content) indicated the following: ntries by non-physicians d meaningful information and information is documented on as approved by the Medical	S09	930	Correction: Director of Qual Management (DQM) or design to inform clinical staff of documentation non-compliance of standard Prevention: Staff in-service on documentation requirements including daily activity of patient Daily revied coumentation for 30 days and monthly thereafter until compliance target achieved ar maintained Responsible Party DQM, CCO	e · er w of d	01/18/2013

State Form Event ID: XGT811 Facility ID: 012132 If continuation sheet Page 8 of 11

PRINTED: 01/17/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 152027	A. BUILDING B. WING	00	COMPLETED 10/02/2012
VIBRA H	ROVIDER OR SUPPLIER	WAYNE	2626 F	ADDRESS, CITY, STATE, ZIP CODE AIRFIELD AVE WAYNE, IN 46807	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	5. The MR for patic by nursing staff indi- out of bed related to Up in Chair for 13 of 6. During an interv hours, staff A3 conf	ent 30 lacked documentation icating the patient was assisted to the physician activity order			

State Form Event ID: XGT811 Facility ID: 012132 If continuation sheet Page 9 of 11

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	DISTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		152027	B. WIN			10/02	/2012
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AIRFIELD AVE		
VIBRA H	OSPITAL OF FORT	WAYNE			WAYNE, IN 46807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0932	410 IAC 15-1.5-6						
	NURSING SERV	ICE					
	410 IAC 15-1.5-6	(b)(4)					
	(b) The nursing so following:	ervice shall have the					
	(4) The nursing si and utilize an ong plan of care base care for each pati	oing individualized d on standards of					
	Based upon docume	ent review, medical record	S09	32	Correction:		01/18/2013
	review and interview	w, the nursing staff failed to			· Director of Quality		
	_	d maintain an individualized			Management (DQM) or designee to	1	
	•	9 medical records (MR)			inform clinical staff of		
	reviewed.				documentation non-compliance		
					· CCO to enforce compliance		
		edure Care Plans (revised 1-11)			per standard		
		ring: " A care plan will be			Prevention:		
		patientwithin 24 hours [by]			· Staff in-service on		
		Plan will address the major			documentation requirements		
	-	nd the rehabilitation potential			including updating nursing care plan	า	
	-	Care Plan will be updated			based on standards of care for each		
		the patient condition changes			patient		
		portant that Care Plans are			Daily review of		
	treatment rendered.	patient's response to the			documentation for 30 days and		
	ucamient rendered.				monthly thereafter until compliance	9	
	2 The Nursing Cor	e Plan (NCP) for patient 22			target achieved and maintained		
	_	care addressing activity			Responsible Party: DQM, CC	O	
		ity) related to the physician					
		f Bed with assistance for the					
	3-27-12 admission.	i Ded with assistance for the					
	5 27 12 ddiiii55i0ii.						
	3. The MR for patie	ent 23 lacked a Nursing Care					
	Plan for the patient.	_					
	4. The NCP for pat	ient 25 lacked a standard of					
		vity (Alteration in mobility)					
	related to the physic	cian activity order Out of Bed					
	with assistance.						
			1		1		1

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152027	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/02/2012
	PROVIDER OR SUPPLIEF		2626 FA	ADDRESS, CITY, STATE, ZIP CO AIRFIELD AVE NAYNE, IN 46807	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETION
	care addressing active related to the physical feet of the physical feet order. The NCP for part mobility goal related order Up in Chair. standard of care for volume/alteration in 30 pound weight gat 19 day hospitalization. During an interval hours, staff A17 included instruction for each patient on Alteration in Mobil 8. During an interval hours, staff A4 concluded the indicated confirmed that the landicate a mobility activity orders and lacked a category for	n renal function related to the ain and renal consult during the on. liew on 10-02-12 at 1250 licated that nursing orientation as to record the ordered activity the NCP standard of care ity section under Goals. liew on 10-02-12 at 1400 firmed that the Care Plans at standards of care. Staff A4 NCP for patient 30 failed to goal related to the physician indicated that the Care Plan or nursing staff to document a on in addition to selecting a			

State Form Event ID: XGT811 Facility ID: 012132 If continuation sheet Page 11 of 11